Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
KEITH S. TURNER, DC

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-14-1440-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 23, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 127.10 (c), the Designated Doctor shall perform additional testing when necessary to resolve the issue in question. The Designated Doctor may also refer an injured employee to other health care providers when the referral is necessary to resolve the issue(s) in question. Any additional testing or referral required for the evaluation is not subject to pre-authorization requirements or retrospective review requirements. Therefore, **NO PRE-AUTHORIZATION IS REQUIRED**."

Amount in Dispute: $949.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2013	CPT Code 97750-FC (16 units) Functional Capacity Evaluation	$949.76	$869.64

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code § 133.10 effective August 1, 2011, outlines the required billing forms and formats.
3. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 206-National Provider Identifier - missing.
   - Referring provider's NPI# is invalid or missing. Please resubmit bill with this information included.
   - Referring provider license prefix and suffix are invalid or missing. Referring provider's state license number

is required when there is a referring doctor listed on the bill; the billing provider shall enter the 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX). Future billings will need to be formatted according to state fee schedule regulations.

- X022-Previously requested information/documentation has not been received.
- X394-Our position remains the same if you disagree with our decision please contact the division for medical fee dispute resolution.
- Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.

5. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on February 5, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

Is the requestor entitled to reimbursement for the functional capacity evaluation rendered on September 28, 2013?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed FCE based upon reason code "206."

28 Texas Administrative Code § 133.10(L) states "referring provider's National Provider Identifier (NPI) number (CMS-1500/field 17b) is required when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number." A review of the submitted bill finds that the referring physician was Designated Doctor Juan M. Villafani, MD, and that box 17b was left blank. The respondent did not submit documentation that Dr. Villafani is eligible to receive an NPI number and to support the denial of payment; therefore, the disputed service will be reviewed per applicable Division rules and guidelines.

28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

CPT code 97750 is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." CPT code 97750 requires direct one-on-one patient contact. The submitted documentation supports the billed service; therefore, reimbursement of four hours is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in Houston, Texas. Per Medicare the provider is reimbursed using the locality of Houston, Texas.

The Medicare Participating amount for code 97750 is $33.44/15 minutes.

Using the above formula, the Division finds the MAR is $869.64. The respondent paid $0.00. As a result, the Division finds the requestor is due $869.64.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $869.64.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $869.64 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	07/22/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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